Alternative Health Insurance Benefits Exchanges

The purpose of the Health Insurance Benefits Exchanges around the country and in the new federal law is to extend the risk pooling and economy of scale advantages of large groups to participants in the individual and small group markets. There are different ways and opinions about how best to accomplish that. This chart lays out salient features of the some of the more prominent models in operation or in recent laws. It was drawn from many different documents, is as accurate as possible, but is meant to be illustrative, not definitive.

	PPACA (March 23, 2010)	Massachusetts (law passed in March 2006, enrollment started in late 2006)	Utah (law passed in 2009, enrollment started 2010)	California law (Sept. 30, 2010)
Scope of Exchange				
Geography	Allows states to choose to form statewide, multi-state, or sub-state (but latter must serve distinct geographic areas within the state, i.e., exchanges cannot compete within a given area)	Statewide, but allows carriers to offer in one, two or all three regions of state.	Statewide, but allows carriers to offer where they want to	Statewide, Board will determine geographic offer requirements

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Insurance Markets	Allows states to choose to meld individual market and small group markets, or to create separate exchanges (or risk pools); small group is defined to be 1-100, but before 2016 states may limit it to 1-50, states could allow larger than 1-100 in starting in 2017. Grandfathered plans in separate risk pool. Non-grandfathered plans must be considered in the same risk pool. FEHBP will purchase through the exchanges. Even if the small group exchange is separate, states can choose to let employers limit employee choices to one level or tier of plans. Nothing in federal statute compels participation in the Exchange. Tax credits for subsidies and cost-sharing, however, are only available inside the Exchange.	Has separate exchanges with different plans for subsidized and unsubsidized individuals. Melds small group (2-50) and individual markets within the Exchange.	Small group only; allows exemption from state mandates added after 1/1/09, set up a defined contribution arrangement for employers and workers to facilitate economic choice. Exchange operates an information only web-portal for individual market policies	Separate market Exchanges for individual and small groups (2-50).

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Governance				
Type of entity	Allows states to choose to put Exchange within an existing state entity (e.g., BOI or Medicaid or state employee program), to create a new state agency, or to designate a non-profit entity to run the Exchange. Even if in a state agency, a state could also define a new multi-stakeholder Board to advise or govern the Exchange. The State could also choose to let the federal government set up and run the Exchange in its borders. HHS Secretary will decide by 1/1/13 if state's own Exchange is making adequate progress toward 1/1/14 operational requirement.	Massachusetts Connector Authority is self-governing separate legal entity from the State, 10 member Board, representation defined in statute	Office of Consumer Health Services, within Office of Economic Development	Independent public entity, separate from all existing agencies and departments, 5 person California Health Benefits Exchange Board specified in statute to have insurance market expertise

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Regulation of insurance				
Across state lines	Allows states to enter multi-state compacts to permit insurers to sell individual products in compacting states, starting in 2016.			
Risk adjustment, risk corridors, and reinsurance	In consultation with NAIC and American Academy of Actuaries, temporary reinsurance and risk corridors and a permanent risk adjustment mechanism will be set up to shift money among non-grandfathered individual and small group plans that attract differential shares of higher risk enrollees, in order to keep all risk pools balanced.			

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Within the state	State Bureaus/Departments of Insurance are expected to maintain solvency, conduct, and regulation compliance functions. Exchanges will determine if specific insurers and plans are eligible to participate in the Exchanges. New insurance regulations (guaranteed issue, premium rating restrictions, end of pre-existing condition restrictions etc. apply outside as well as inside the exchange. HOWEVER: if the state refuses to set up an Exchange and conforming statutes, then some federal regulation of individual and small group markets, at least that inside the exchange, will be inevitable.	Rules of issue and rating restrictions are identical inside and outside the exchange.	There is no attempt to regulate offer or premiums inside or outside the exchange in Utah.	CHBE Board will require plans inside and outside the Exchange to offer "standardized" plans as defined by the Board. Plans outside exchange are only allowed to offer plans in 1 of 4 tiers of PPACA (and no catastrophic).
Management of competition within the exchange				

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Information	Exchanges must have consumer assistance hotline, website with comparative info, rating system for plans, navigator program to assist consumers (could be insurance agents/brokers but they cannot be paid for specific enrollment choices), cost calculator for consumers Facilitate money flows between people, governments, and insurers	Broker commission is $10 pmpm for section 125 plans (workers in firms that do not offer must have access to these, which enable worker premium payments to be pre-tax) and 2% of premium for all others	Requires brokers to disclose their commissions and compensation to their customers before selling a plan. Sets commission within exchange to $37 per employee per month Requires insurers to report benefits, provider networks, speed of claims payment and percent of successful appeals. Department of Insurance must report each insurer's solvency rating. Office of Consumer Health Services must maintain web portal with applications for public and private insurance. Facilitate premium collection from workers and firms.	Plans must reveal detailed information re: operations, quality measures, cost-sharing, OOP limits Require plans to provide regular updates on participating providers in networks.

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Benefits	Exchange must certify each “qualified health plan,” (QHP) pursuant to HHS criteria; QHPs consist of “essential benefits” defined by HHS and will include : Ambulatory, emergency, hospital, maternity, mental and substance abuse, drugs, labs, preventive and wellness, pediatric (incl. oral and vision), with limits on cost-sharing (deductibles = d = $2000/4000, out-of pocket (OOP) max $5950/$11900), and with specific actuarial values (AVs). States can add criteria to federal ones (regulation forthcoming) to make it a more selective contractor of plans, or a more passive clearinghouse of all willing and eligible plans. This is perhaps the key strategic choice.	Minimum creditable coverage was defined by the Connector (Exchange) Board.	Requires employers to offer workers a choice through the Exchange; Allows employer to select a default plan, if worker does not affirmatively select another, show proof of coverage through a spouse, or affirmatively decline coverage, the worker is enrolled in default plan	

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Types of plans	Bronze = 60% AV Silver =70% AV Gold = 80% AV Platinum = 90% AV Catastrophic: for those under 30 or who face financial hardship, d = OOP max of QHP and 3 primary visits with zero copay; all plans must be accredited by agency recognized by HHS, include essential community providers, comply with performance data reporting requirements, implement market-based strategies for quality improvement. States can add criteria to federal ones (regulation forthcoming) to make it a more selective contractor of plans, or a more passive clearinghouse of all willing and eligible plans. This is perhaps the key strategic choice.	Bronze, silver, gold and young adult plans, all offer minimum creditable coverage, main difference is cost-sharing (and therefore premium)	Requires insurers to offer at least one federally qualified high deductible plan with OOP max no larger than 3 times allowed annual deductible; Also requires all insurers to offer at least one other plan with 15% higher AV than the standard one defined above. Creates Utah NetCare Plan to replace COBRA, mini-COBRA, and individual conversion products, target AV = 33% below current average for such products.	Exchange is explicitly given power to bargain and selectively contract with carriers on specific plans to be included. Rules within and without Exchange generally the same, except carriers are not allowed to offer "catastrophic, under 30" coverage outside the exchange.

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Types of insurers	Licensed and good standing in the state, agrees to offer at least one silver and one gold plan, charge the same for the same plan in and outside the Exchange; Local non-profit Co-ops could qualify for federal start-up grants, loans, and technical assistance; The Federal OPM (which runs FEHBP now) is charged with ensuring that at least 2 multi-state insurers also offer QHPs for individuals and small groups in each state's Exchange. At least one must be non-profit. All must be licensed in the state. All state (and federal) laws re: guaranteed issue, rating restrictions, end of pre-existing condition restrictions, etc., apply to all plans in exchange including Co-ops and Multi-state plans. Most also apply to plans sold outside exchange.	Licensed and good standing in the state.	Insurers who sell through exchange must promise to remain for 2 years, participate in risk adjustment mechanism,	Licensed carrier or managed care organization (CA regulates these separately) CHBE Board to establish criteria for entering Exchange. Insurers/MCOs must offer at least one plan in all 5 tiers (bronze, silver, gold, platinum, young/catastrophic)

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Premiums	Can vary by geographic rating area (set by state), age (3:1), smoker (1.5:1), wellness program participation (up to 30% discount) Insurers must consider all enrollees in non-grandfathered plans in the individual and small group markets, respectively, to be members of the same risk pools. Exchanges have the power to exclude plans for "unreasonable" premium increases, criteria jointly determined by states and HHS.	No medical underwriting or variation on health status allowed, can vary by smoking status, geography, age; 2:1 overall rate band (most expensive offer for same product can be no more than twice the cost of lowest offer for the same product).	Limits on pre-existing condition restrictions (6 mo. Look back, 12 month wait) medical underwriting allowed but limited to +/- 30%.	Board will determine this later, pursuant to PPACA.
Interactions with private insurance outside exchange	Risk adjustment will extend to all non-grandfathered plans, in or outside the exchange.		Utah Defined Contribution Risk Adjuster is a non-profit entity with a specified Advisory Board within the Insurance Department. Does both pro- and retrospective risk	

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			adjustment.	
	Must set up application process for workers for whom their OOP premium would exceed 9.5% of their income, for they are eligible to purchase (and possibly get tax credit subsidies) in the Exchange			

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Flexibility to create Basic Health Program (BHP) for low income individuals not eligible for Medicaid	Allows states to decide to cover those with incomes between 133% and 200% of FPL by excluding them from the Exchange but contracting with standard health plans to provide them with at least essential benefits. Federal govt. will supply the state with 95% of subsidy tax credits that the individuals would have received for purchase of second lowest cost Silver plan in the Exchange. Premiums charged to the individual may not exceed what the individual would have paid in the exchange. Cost-sharing may not exceed that associated with platinum benefit level for those with incomes < 150% FPL and gold for all others (6% of AV). MLR rule of 85% would still apply. States are required to ensure plan choice within the BHP if feasible.			

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Interactions with Medicaid				
Enrollment and eligibility determination	HHS must establish standards for a common application form for Exchange subsidies, Medicaid, and SCHIP. States can use their own form/procedurs, if consistent with HHS standards. Must inform applicants what they are eligible for (one-door). Enrollment will take place during one month open enrollment period, or in case of a life-changing event as in current employment law (marriage, birth, etc).	Massachusetts has one enrollment form for both Medicaid and the Exchange, and it's SCHIP program accepts children up to 300% of poverty, so many families have some members in both the Exchange and Medicaid or SCHIP. Therefore enrollment and eligibility coordination is a major focus of both entities.	None.	Statute provides guidance to collaborate with state high risk pool, Medicaid and CHIP to allow individuals moving between exchange and these programs to remain enrolled with current carrier and provider network. Board will decide other details later.